

***United States Court of Appeals
for the Second Circuit***

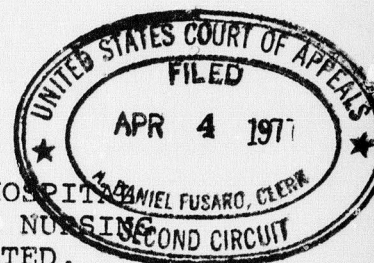


**BRIEF FOR
APPELLEE**

77-7102

To be argued by
GEORGE C. MANTZOROS

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT



NEW YORK ASSOCIATION OF HOMES FOR AGING, INC., HOSPITAL
ASSOCIATION OF NEW YORK STATE, INC., ST. CABRINI NURSING
HOME, INC., MOHAWK VALLEY NURSING HOME INCORPORATED,
DAUGHTERS OF SARAH NURSING HOME CO., INC. and LORETTO
REST NURSING HOME, INC., etc.,

Plaintiffs-Appellants,

-against-

PHILIP L. TOIA, as Commissioner of Social Services of
the State of New York, ROBERT P. WHALEN, as Commissioner
of Health of the State of New York, PETER GOLDMARK, as
Director of the Budget of the State of New York, and
HUGH L. CAREY, as Governor of the State of New York,

Defendants-Appellees.

BRIEF FOR DEFENDANTS-APPELLEES
IN DOCKET NO. 77-7102

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Issues Presented

1. Whether State regulations promulgated pursuant to New York Public Health Law, as amended by Chapter 76 of the Laws of 1976, can be separately challenged as unconstitutional without a constitutional challenge to their statutory authority.

2. Whether extrinsic evidence offered by appellants that their actual costs were not fully reimbursed, circumstances of losses and possible closings, and alleged failure to comply with statutory procedures, are relevant and sufficient to prove that the State's new regulations Part 86-2 directly conflict with the federal reimbursement standard of "reasonable cost-related basis" (42 USCA 1396a[a][13][A]) to warrant a preliminary injunction and a mandatory roll-back to the 1975 rates.

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FOR THE SECOND CIRCUIT

DOCKET NO. 77-7102

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Preliminary Statement

Plaintiffs-appellants - two associations and five
owner - operators of nursing homes, allegedly as representa-
tives of a class of about 387 nursing homes (Complaint,

par. 23) (JA 9*) appeal from a denial by the United States District Court (Griësa, J.) of their "motion for preliminary injunction on a class basis" (JA 2020-2022). The District Court then explained (JA 2023):

"[THE COURT]: However, I am not denying the preliminary injunction and I am reserving my decision with respect to individual cases of individual homes that wish to present evidence to me * * *

"I think the record should reflect that as of December 22 the motion for a preliminary injunction was in effect withdrawn, except as to requests for relief for the months of November and December, and it was not until about the 31st day of January or the 1st of February that I heard about any reactivation of the preliminary injunction motion. We had a hearing on February 4. We are now having a hearing on February 9 at the request of the plaintiffs, on the representation that there were certain homes in dire condition, threats of closing,

* References to Joint Appendix indicated by prefix "JA".

and so forth. I have heard the evidence in detail on the Loretto Home and the Walsh Home.* I must say the evidence was most revealing, and the record shows what the results have been."

On March 15, 1977, this Court (Feinberg, Timbers, Davis, J.J.) denied appellants' motion for an injunction pending appeal "without prejudice to renewal before the panel to hear the appeal".

Appellants' application for a "preliminary injunction enjoining" the application of "Part 86-2 of Title 10 of the New York Code of Rules and Regulations" (Br. p. 3), in purpose and effect, goes much beyond the primary and traditional function of a preliminary injunction to maintain the status quo and calls for the ultimate affirmative relief by an "order* * *to compute medicaid reimbursement rates designed to reimburse plaintiffs and* * * class for their reasonable costs* * *" (Complaint JA 44). But the new federal standard provides, 42 U.S.C.A. 1396a that a (a) "State plan for medical assistance must (13) provide (E) effective July 1, 1976, for payment* * *on a reasonable

* JA 564-570 (The Director of the Budget approved the certifications by the Commissioner of Health on February 10 and 18, 1977, of rate revisions for Loretto). JA 571-575 (Approval of rate revisions certified on February 17, 1977, for Mary Manning Walsh Nursing Home Company).

cost related basis, as determined in accordance with methods and standards which shall be developed by the State on the basis of cost-finding methods approved and verified by the Secretary". Thus, without any constitutional challenge to the underlying New York statutory authority for Part 86-2 in Public Health Law § 2807(e) (see Chapter 76 of the Laws of 1976) mandating the new reimbursement standard linking the standard of quality of care (§ 2803[1][c]) and the standard that "payment for costs* * * shall not exceed those which would be paid in the normal course of business by a prudent buyer of such supplies or services" (§ 2808[1] subd. a) (emphasis added), the appellants seek -- tantamount to a quick knockout -- a preliminary injunction enjoining the Part 86-2 regulations (JA 521, 533-537). Appellants' proposal would, in effect, create a legislative-administrative vacuum by a proposed roll-back to the 1975 rates, under a different statutory standard now repealed, notwithstanding the absence of statutory authorization and appropriations prohibited by State Finance Law §§ 40(2)(a), 41, and by New York Constitution, Art. 7 § 11. Moreover, such a proposed class-wide roll-back to prior 1975 rates would adversely affect and block higher reimbursement rates received under Part 86-2 by about 103 nursing home facilities/ (JA 221) (Tr. 11/19/76 p. 4; 12/17/76 pp. 151-153) (see also District Court's "findings and

conclusions" (JA 2020-2021) "There are differences in the rates granted to the homes* * *There are substantial differences in the effects of various rates").

The appellees assert in their Answer that Part 86-2 was "made and adopted pursuant to and in compliance with the New York Public Health Law of the State of New York, as amended by Chapter 76 of the Laws of 1976 (JA 233). The quality of care (Public Health Law § 2803[1][c]) -- "prudent buyer" (id. § 2808[1] subd. a) standard (id. § 2807 [2][e]) (Chapter 76 of the Laws of 1976 § 11[e]) which has not been constitutionally challenged -- is presumptively constitutional and in full compliance with the new federal reimbursement standard "reasonable cost related basis" (42 U.S.C.A. 1396a[a][13][E]).

Statement of the Case

A. The Complaint

The Complaint (par. 1) (JA 1) seeks a declaratory judgment and preliminary and permanent injunctive relief* * * to declare illegal and enjoin the new, reduced, rates at which the defendants propose to reimburse non-profit

residential health care facilities for services rendered to patients pursuant to the joint federal and state medical assistance program (hereinafter "Medicaid program") provided for under Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (hereinafter "Medicaid Act") and "to declare illegal and enjoin the regulations pursuant to which the challenged rates were calculated".

Plaintiffs allege that (Complaint, par. 1[A])

(JA 2):

"The challenged regulations and rates do not, and are not calculated to, provide reimbursement to the plaintiffs and members of the class based on the reasonable cost of rendering services to medicaid -- sponsored patients* * *".

They further allege (Complaint, par. 82)(JA 29) that "members of the plaintiff class will be unable to meet the costs of operating their facilities" and that (id. par. 85)(JA 30) any retroactive application, if applied, would "lead to the immediate insolvency of the members of the plaintiff class, with the result that thousands of elderly patients in the State of New York will be immediately deprived of essential, life sustaining health care services".

Fifteen causes of action are alleged; some allege federal constitutional claims (e.g., First Cause of Action, par. 87 [JA 30], under the Supremacy Clause Art. VI, cl. 2; Second Cause of Action, par. 90 [JA 31], Art. 1, Section 10, etc.), while others (Sixth to Tenth Causes of Action), allege state administrative procedural law claims normally judicially reviewed under New York CPLR Art. 78, for example, that certain statutory requirements were not followed in the adoption of Part 86-2 of the Regulations (e.g. alleged lack of consultation with Medical Advisory Committee [par. 105][JA 34]; alleged failure to comply with statutory requirements of the N.Y. Administrative Procedures Act in adopting regulations on an "emergency" basis [pars. 107-109][JA 35], without 21 days notice [pars. 111-113][JA 35-36] and without 60 days notice under Public Health Law § 2807(4)[pars. 116-118][JA 36] -- notwithstanding the legislative mandate of Section 16 of Chapter 76 of the Laws of 1976 which "suspended" Section 2807(4). The District Court noted its "Article 78" nature and observed that there is a "question of Law" and that "we really have no constitutional issue and no case in controversy* * *" (JA 679).

Apparently, the Complaint is predicated upon a decision in Kaye v. Whalen (Sup. Ct. Albany Co. Sp. T. September 16, 1976) (Complaint, pars. 50, 108) (JA 17, 35). However, on February 14, 1977, the Supreme Court, Appellate Division, Third Department, reversed on the law and the facts, and dismissed the petition under Article 78 challenging the regulations of the Department of Health (See Pl. Addendum Document No. 9).

B. Defendants' Answer and Motions

In addition to a motion to dismiss the action (F.R.C.P. Rules 12[b][1][3][6]) (dated Nov. 30, 1976) (JA 191) and a motion to transfer the action to the U.S. District Court for the Northern District of New York (dated Nov. 19, 1976) (28 U.S.C. 1404[a]), defendants served and filed an Answer (dated January 20, 1977) (JA 225). The answer, inter alia, alleges that the Department of Health developed regulations pursuant to and in compliance with the legislative mandate in Chapter 76 of the Laws of 1976, to which it refers (par. 21) (JA 228), and that "in some instances new rates were lower than the 1975 rates and in some instances the new rates were higher than the 1975 rates" (par. 23) (JA 228).

The Assistant Commissioner for the Division of Health Care Financing explained the difference in the application of the rates in November 1, 1976, as follows (JA 221):

"3. The records* * * show that the rates issued November 1, 1976 for the period January 1-December 31, 1976 for said 286 facilities increased the reimbursement rates of 103 of the facilities; decreased the rates of 176 and remained the same for seven in comparison with the prior interim rates". (emphasis added)

As affirmative defenses, the defendants asserted, among others, that the action is barred by the Eleventh Amendment (par. 49) (JA 231); the plaintiff associations which do not allegedly own or operate non-profit residential health care facilities, are not proper parties and have no standing to sue (par. 52) (JA 232); venue in the U.S. District Court for the Southern District of New York is improper (par. 53) (JA 232);* plaintiffs have adequate

* See defendants' Notice of Motion to Dismiss pursuant to F.R.C.P. Rules 12(b)(1)(3)(6) including objection to venue in the Southern District which placed an unnecessary burden and hardship in time, effort and expense upon defendants' witnesses who reside in Albany where all the files and records are located. JA 196-197. Weil v. New York State Department of Transportation, 400 F. Supp. 1364 (S.D.N.Y. 1975). See also, defendants' Notice of Motion to Transfer the Action to the Northern District of New York (28 U.S.C. 1404[a]) dated November 19, 1976 (Tr. 11/24/76, pp. 2-4).

remedies at law and in the Courts of the State of New York for judicial review of administrative determinations (par. 54) (JA 232); the rates and regulations, Part 88 adopted on September 30, 1976 and its successor Part 86-2 adopted on November 29, 1976, were made and adopted pursuant to and in compliance with the New York Public Health Law as amended by Chapter 76 of the Laws of 1976 (par. 55) (JA 233); and, that pursuant to the doctrine of abstention, this action should be dismissed pending determination and interpretation of the challenged rates and regulations by the Courts of the State of New York (par. 56) (JA 233).

C. The Motion for Preliminary Injunction
and the Evidentiary Hearing

Plaintiffs' first motion for preliminary injunction (Order to Show Cause dated November 19, 1976) (JA 45), consisted of some financial data and alleged losses by the plaintiffs St. Cabrini Nursing Home, Inc., Mohawk Valley Nursing Home, Inc., Margaret Tietz Center for Nursing Care, Inc., and Loretto Rest Nursing Home Co. Inc. The District Court held evidentiary hearings. The record discloses that plaintiffs were principally relying upon extrinsic evidence and objections that "costs were not met, that rates were

reduced" (JA 1854) to secure a quick preliminary injunction. The Court observed that they did not attempt to "explain why these new rates were not reasonable" (JA 1356) and "basically, they were talking about actual costs or actual losses and the translation of that into reasonableness, in my view, was simply not made" (JA 1854).

Defendants presented evidence in opposition including "findings of fact" (JA 2056, 2071, 2086, 2104, 1880, 2122, 2130) relating to recommended cost savings under the new "quality of care rating" -- "prudent buyer" standard now mandated under the Public Health Law amendments in Chapter 76 of the Laws of 1976, Section 11(e), amending Public Health Law § 2807(3). Some of the nursing home facilities as the four plaintiff companies operate under the "nursing home companies law" (Public Health Law Art. 28-A) providing for mortgage financing and whose financial situation is different. (See JA 780, 786, 1930, 1941, 1961).

The District Court carefully and meticulously examined the financial situation of those plaintiff nursing homes which alleged losses, including the Department of Health's presentation on December 17, 1976 (JA 1448) in "findings of fact" Exhs. "AA" (Mohawk) (JA 2056); "BB"

(Margaret Tietz) (JA 2071); "CC" (Daughters of Sarah) (JA 2086); "DD" (St. Cabrini) (JA 2104) and on February 9, 1977 (JA 1880) as to Mary Manning Walsh Nursing Home Co. (Exh. "EE") (JA 2122), Loretto Geriatric Center (Exh. "FF") (JA 2130);* and Beth Abraham Nursing Home (Exh. "A") (JA 2217) (hearing adjourned pending further administrative review) (JA 2216).**

One of the plaintiffs, Mohawk Valley, had experienced prior financial difficulties as a result of "some real management problems" requiring the Commissioner of Health to appoint his assistant regional director in Syracuse to Mohawk's board of trustees (JA 1341). The "management problems" were described as follows (JA 1342):

"[Dr. Cicero]: * * * There are deficiencies of various kinds, one of the major problems is the poor administration in relation to deployment of staff* * * it is our position that in addition to savings being made, simple redeployment of personnel among other things would change that rating from a needs improvement to at least good federal, and I think it is very important for the Court to understand what that would mean, because a different ceiling and a higher ceiling would be applied, with simple deployment of staff". (emphasis added).

* See JA 1456 (December 17, 1976). Exhibits renumbered on February 9, 1977 (JA 1887).

** Report scheduled for hearing on March 29, 1977, adjourned. and heard March 31, 1977.

The Health Department's professional staff proposed and recommended the following reductions and operational cost savings for the following plaintiffs: Margaret Tietz Nursing Home: \$1,191,222.00 (Defs. Exh. "BB") (JA 2071); Daughters of Sarah Nursing Home Co.: \$447,246.00 (Defs. Exh. "CC") (JA 2087); Mohawk Valley Nursing Home: \$629,247.00 (Defs. Exh. "AA") (JA 2057); St. Cabrini Nursing Home, Inc.: \$482,400.00 (Defs. Exh. "DD") (JA 2105). St. Cabrini did not accept the proposed reductions; but Daughters of Sarah "accepted" \$159,488.00 (JA 2087) and Mohawk "accepted" \$186,755 (JA 2057). The District Court examined the St. Cabrini financial situation (JA 1550 et seq.).

The District Court was informed of the changes of rates effective January 1, 1977 with the addition of a "trend factor" of about "4 to 5 percent" (JA 1649, et seq.) which required a new appraisal of the situation "to consider the new proposal as a response to the problems that have been raised in court" (id. 1652-4, 1660-3) and the proposal to resort to the regulations' administrative appeal procedures (id. 1666 lines 13-15, pp. 1667-8). The District Court directed production of the list of new January 1, 1977 rates (JA 1679-1682) and directed the defendants "to consider

exactly how hardship cases which are not handled by the new rates are taken care of, ruled on quickly and as simply as possible and as objectively as possible* * *" (JA 1683). The list was produced (JA 1691). The District Court adjourned the hearings with the direction that the "Department will make a good-faith effort to hear both sides of the controversy and will come up with as objective an adjudication as possible of the problem" and directed plaintiffs to "obtain[ing] the emergency or critical cases from your clients, listing those cases and submitting them to Dr. Cicero, if you feel it is sufficient to simply send me copies of things and work out a schedule of hearings with Dr. Cicero and his staff* * *" (JA 1769-1770) and the District Court observed that "as far as the preliminary injunction motion it seems to me that the matter simply has to be given further thought. We have got new developments today and no decision can be made" (id. 1770, lines 14-17). Pursuant to the District Court's direction, the administrative reviews were conducted and reports as to about thirteen nursing homes were delivered to the District Court (JA 1816, 1826-1828).

To illustrate: Deputy Commissioner Dr. Cicero reported and testified on December 17, 1976 as to the results of the meeting of the staff of the Department of Health and the representatives of plaintiff Loretto Geriatric Center (JA 1458). The "findings of fact" (Defs. Exh. "FF") (JA 2130, 1459) disclosed that the Department proposed cost reductions of \$907,904.00 and recommended that the "[f]acility can sustain rate reductions by making reductions in several areas of operation without causing irreparable harm to patient care" (JA 2132). Plaintiff Loretto agreed to the Department's proposed reduction of \$907,904.00 (JA 1458). The position and views of the plaintiff Loretto were also reported under the headings "Comments" and "Facility Position" (Defs. Exh. "FF") (JA 2130). The District Court observed (JA 1483):

"THE COURT: * * *If the Loretto Home is at all typical* * * If there are other institutions like the Loretto Home, I would not be warranted in granting any injunctive relief because cuts have been agreed on in the non-nursing side; the cuts are documented; they are not protested. And as far as the nursing side, there is a willingness to promptly try to come to a determination on whether there is a bona fide claim for nursing* * *".

In connection with plaintiffs', in effect, renewal of the preliminary injunction, the Court on February 14, 1977 referring to the hearing of December 22, 1976, observed (JA 1820):

"THE COURT: * * *as of that date, the plaintiffs' attorneys announced to me that they were not, at that time, pressing for the granting of any injunctive relief relating to rates subsequent to the period January 1977* * *."

and the Court continued (JA 1821):

"* * *beginning at page 124 of the transcript of December 22nd, and I stated that as far as limiting -- as far as an application limited to November and December, I felt that it was a radically different application than was presented before because it was in part retrospective, or it could be argued it was retrospective, and I stated that I was not intending to rule on such an issue because there was not an adequate presentation.

"So that is how it was left* * *".

Plaintiffs proposed to present evidence relating to the Department's proposed operational cost reductions for several other nursing homes, including Mary Manning Walsh Nursing Home (See Defs. Exh. "EE") (JA 2122) (JA 1830). The hearing

for Loretto, Mary Manning Walsh, Plaza and Mohawk Valley was held on February 9, 1977 (JA 1884) (Loretto JA 1884-1963; Mary Manning Walsh id. 1963-2003). The hearing as to Plaza (JA 2004) was adjourned since the Department of Health staff and representatives of Plaza were conferring in Albany "over the 'proposed cuts'" (id. 2011, see also 2023, lines 22-24). Mohawk Valley did not present evidence (JA 2019, lines 20-24; 2024, lines 8-10). The Department of Health has now certified rate revisions for Loretto and Mary Manning Walsh Nursing Home to the Director of the Budget who has approved (JA 564-575).

D. The Basic Statutes and Challenged Regulations (Part 86-2)

The challenged regulation, 10 NYCRR Part 86-2, has been filed on December 31, 1976, with Region II of the Department of Health, Education and Welfare (JA 521). Part 86-2 is an amendment to the New York's Plan and provides for "Methods and Standards for Establishing Payment Rates -- Residential Health Care Facilities" (JA 524) and attachment 4.19-D (JA 525):

"* * *describes the methods and standards used by the State for determining payments to be made

on a reasonable cost-related basis to skilled nursing homes and intermediate care facilities for services provided under the plan. The description include[s] requirements for cost-finding and cost reporting, auditing procedures, items of allowable cost, and methods and standards for determining cost-related payment rates".

Section 86-2.10 of Part 86-2 establishes the methodology for the "computation of basic rate" (JA 533) and Section 86-2.11 establishes the "ceilings on allowable costs for reimbursement purposes" (JA 534) by separately grouping the facilities with respect to "size" (§ 86-2.11[a][1]) and six "functions" (§ 86-2.11[a][2]). Section 86-2.11(f) states that "Ceilings shall not be imposed on costs for any rated function for which a facility receives a 'very good' service rating". However, "allowable costs for reimbursement" may "not exceed" a certain "percentile of the per diem range of costs for facilities receiving 'Good-State' service ratings for the appropriate size group" depending upon the rating, to wit:

- (1) "Good-State" -- 60th percentile
(§ 86-2.11[b]);
- (2) "Good-Federal" -- 35th percentile
(§ 86-2.11[c]);

- (3) "Needs-Improvement" -- 25th percentile (§ 86-2.11[d]);
- (4) "Unacceptable" -- 10th percentile (§ 86-2.11[e]).

Since 1966, New York State has allowed nursing home reimbursement to be cost based. Part 86-2 adopted in 1976, pursuant to the mandate of Section 11(e) of Chapter 76 of the Laws of 1976 (Public Health Law § 2807[e], Book 44, McKinney's Cum. Annual Pocket Part 1976-1976 at page 49), a cost reimbursement methodology, linking the quality rating system with "no less than five specific categories" (Public Health Law § 2803[1][c]) (see the six "functions" in Part 86-2 § 86-2.11[a][2][JA 534]) with the "prudent buyer" concept (id. § 2808[1][a] "shall not exceed those [costs] which would be paid in the normal course of business by a prudent buyer of such supplies or services").

The following hypothetical demonstrates the application of 86-2.11 subds. (a) and (b) (JA 675-686). Suppose that the costs for the function "Food-Nutrition" (§ 86-2.11[a][2][ii]) for 20 facilities rated "Good-State" range from a low of \$3.00 to a high \$9.00, notwithstanding each of the 20 facilities have the same "Good-State" service rating. The 60th percentile - not percentage of costs - is \$7.00

so that those of the 20 facilities which "exceed" the cost of \$7.00 for "food-nutrition" will not be reimbursed under the new legislatively mandated quality of care rating -- prudent buyer standard (Section 11 of Chapter 76 of the Laws of 1976). Presumably, the facilities, whose costs for the function exceed \$7.00, may not have adopted cost efficient and economical procedures for procurement of goods and services as evidenced by the lower cost range between \$3.00 to \$6.00 of the other facilities with the same "Good-State" rating. A reimbursement of \$3.00 of costs incurred by one or more of the facilities with a "Good-State" quality rating would be a zero percentile of costs in the food "function" category. The "percentile" is like a norm; the 60th percentile (§ 86-2.11[b]) allows reimbursement of costs above the \$3.00 cost, in the example above, and up to and including reimbursement for costs of \$4.00; \$5.00; \$6.00; and \$7.00 -- but no reimbursement is allowed for costs of \$8.00 and \$9.00 which clearly indicate inefficient and uneconomical operations requiring reductions and savings down to \$7.00 -- the 60th percentile. The percentile -- or norm -- is accordingly reduced according to the lower quality of service rating: "Good-Federal" (35th percentile) (86-2.11[c]); "Needs Improvement" (25th percentile) (86-2.11[d]); "Unacceptable" (10th percentile) (86-2.11[e]) -- with no ceiling in the "Very-Good" service rating

(86-2.11[f]). Mohawk, for example, would have a higher percentile if it had a higher quality rating (JA 1342). To illustrate: applying the rationale to the hypothetical example: the "Good-Federal", "Needs Improvement" and "Unacceptable" ratings are below the "Good-State" standard which has concomitant higher costs which accounts for the higher -- 60th percentile (86-2.11[b]) (JA 534). Indeed, even under the lower ratings, the 35th, 25th and 10th percentiles allow over the \$3.00 cost to the facility in the "Good-State" -- the lowest per unit cost -- in that category -- which represents the most "prudent-buyer" in the "Good-State" rating and at the same time providing services at equal quality with the other facilities in the same "Good-State" rating group. The lower standard involves lower costs. Thus, a facility rated "Unacceptable" with a \$3.00 cost for the "Food" function is not meeting the quality of the facility rated "Good-State". Accordingly, the 10th percentile in the "Unacceptable" rating (86-2.11[e]) is necessarily lower than the 60th percentile in "Good-State" (id. subd. [b]) -- but in any event, there is reimbursement of cost under the 10th percentile of about \$4.00.

The word "ceilings" does not mean or connote any absence of reimbursement for reasonable costs. Indeed, the percentiles -- establishing norms in each group -- provide for reimbursement above the lowest cost per unit in each rating.

The Associate Director, Division of Health Care Financing of the Department of Health, explained that (JA 202):

"3. Regardless of the actual effective date of the Federal requirement [42 U.S.C. 1396a (13)(E)] that long term rates be developed on a reasonable cost related basis, the New York State 1976 method meets the stated criteria. In fact, since 1966 New York State has allowed nursing home reimbursement to be cost based."

and he further stated (JA 203):

"4. The 1976 rates were based on 1974 costs of each residential health care facility, subject to ceilings and disallowances, and trended forward into 1976. The ceilings for 1976 were developed as percentiles of the per diem range of costs of facilities receiving the same service rating for each of 6 specific Functions* * *".

* * *

"6. The existence of actual expended costs is by no means synonymous with reasonable costs. Both Federal and State law anticipate the development of reimbursement that is based on costs, but which may limit liability to a reasonable level below actual costs".

A phase-out and phase-in of the new 1976 reimbursement rates under Part 86-2 has been conducted by the staffs of the Department of Health and Division of the Budget by management survey conferences with the staffs of the facilities (e.g., JA 1900-1921) and review procedures (Part 86-2 § 86-2.14). The Division of the Budget in February 1977 approved certain rate revision increases for plaintiff Loretto Geriatric Center and for the Mary Manning Walsh Nursing Home (JA 564-574). In addition, the trending factor of about four percent resulted in an increase for some facilities on January 1, 1977 (JA 1649). Moreover, as to the recoupment by the legislatively mandated retroactive application of the rates to January 1, 1976 (§ 11[e], Chapter 76 of the Laws of 1976) (See Answer, JA 231), the Department of Health and Division of the Budget have offered to defer demands for recoupment (JA 709, 1538).

Contrary to plaintiffs' state law claim -- reviewable under Article 78 -- that "60 days" was not given to them (Complaint, Ninth Cause of Action, JA 36-37), Section 16 of Chapter 76 of the Laws of 1976 expressly "suspended" the notice provision of Public Health Law, § 2807. Nevertheless, plaintiffs did have some notice since the "prudent buyer" standard was previously adopted in 1975

(§ 2808[1][a]), and Deputy Commissioner, Dr. Frank T. Cicero, testified on this subject of notice, as follows (JA 1551 line 25-1556):

"[Dr.] Cicero: I think, your Honor, that clearly the nursing home groups in this state did know the law, did know the ramifications of the law and did know what prudent buyer was all about and did know what the rating system was all about.

Your Honor, we met with every nursing home operator in the State of New York to discuss the rating system and all the ramifications.

THE COURT: When did you meet?

[Dr.] Cicero: All during the course of this year, we had selected meetings by regions* * *."

Admittedly, the exact dollar rate -- "impact" -- which was not then known, he said, was not given (JA 1555, line 1).

The Department of Health represented to the District Court (see affidavit of Dr. Glenn E. Haughie, Deputy Commissioner) as follows (JA 199-200):

"2. * * *to your deponent's knowledge neither the deponent nor the Department of Health had received any indication from the named residential health care facilities on an intent to cease operation.

3. The State Hospital Code prohibits a medical facility from discontinuing operation or surrendering its operating certificate unless it gives the Commissioner of Health 90 days notice of its intention to do so and obtain its written approval (10 NYCRR §§ 401.3[f], 801.3[f])

4. It would not be consonant with the interests of the Department of Health and the people of the State of New York that facilities representing a needed health resource be given approval to cease operation.

5. The fact that neither the Department of Health nor the State are to be considered as being in a competitive or adversary situation vis-a-vis the plaintiff facilities must be emphasized. It is not part of the State's plan for the provision of health resources that facilities which constitute part of those resources close their doors to those in need of the care those facilities are providing. Both the plaintiff facilities and the State of New York are confronted with financial difficulties arising out of the same economic climate but the State is not using a financial crisis to close residential health care facilities".

E. The District Court's Decision

The District Court, upon plaintiffs' renewed application on or about January 31, 1977, denied the motion for preliminary injunction, as requested, on behalf of and

applicable to the "class" (JA 141, 143). However, the District Court did not deny any relief by preliminary injunction to individual facilities, stating (JA 2023-2024):

"THE COURT: * * *However, I am not denying the preliminary injunction and I am reserving my decision with respect to individual cases if individual homes that wish to present evidence to me* * *.

"I think the record should reflect that as of December 22 the motion for a preliminary injunction was in effect withdrawn, except as to requests for relief for the months of November and December, and it was not until about the 31st of January or the 1st of February that I heard about any reactivation of the preliminary injunction motion. We had a hearing on February 4. We are now having a hearing on February 9 at the request of the plaintiffs that there were certain homes in dire condition, threats of closing, and so forth. We have taken this day. I have heard evidence in detail on the Loretto Home and the Walsh Home. I must say the evidence was most revealing, and the record shows what the results have been.

"I would have heard the evidence on the Plaza Home, except for the fact that the administrative review as to that home is now in progress* * *.

"I would have heard the evidence as to Mohawk Valley, only the man from Mohawk Valley did not stay around* * *".

The District Court's denial of the motion for preliminary injunction on behalf of the class was made on the following "findings and conclusions" (JA 2020-2021):

"THE COURT: * * *The record amply demonstrates that there are differences on the rates granted to the homes* * * There are differences with respect to the procedures engaged in by the Department of Health and the Department of the Budget with respect to these homes. There are differences, substantial differences, in the financial condition of the different homes. There are substantial differences in the effect of the various rates.

* * *

I think we are dealing with request for relief which would involve millions of dollars of additional money to the members of the plaintiff class over what rates may be in effect, this is something which this Court must view seriously, it must view carefully, and it cannot, in my view, be dealt with on a mass basis no matter how much work is involved* * *". (emphasis added)

POINT I

PUBLIC HEALTH LAW 2807(2)(e) IS PRESUMED CONSTITUTIONAL. EXTRINSIC EVIDENCE THAT ACTUAL COSTS WERE NOT FULLY REIMBURSED AND CIRCUMSTANCES OF LOSSES AND POSSIBLE CLOSINGS, ARE IRRELEVANT AND INSUFFICIENT TO SUPPORT INFERENCES OF CONFLICT WITH 42 U.S.C. (1396a[a][E]) ("REASONABLE COST RELATED BASIS") TO WARRANT A PRELIMINARY INJUNCTION AND A RATE ROLL-BACK

Public Health Law 2807(2)(e) (Ch. 76, Laws of 1976) establishing reimbursement guidelines - linking 2803(1)(c) (quality of care rating) with 2808(1)(a) ("payment for costs* * shall not exceed [costs]* * *paid in the normal course of business by a prudent buyer* * *") - is a "State statute[s], like federal ones,* * *entitled to the presumption of constitutionality until [its] invalidity is judicially declared" (Davies Warehouse Co. v. Bowles, 321 U.S. 144, 153 [1943]). The propriety, wisdom, necessity, utility and expediency of legislation are exclusively vested in the Legislature. Katzenbach v. Morgan, 384 U.S. 641, 656-656 (1966). Because of this presumption in favor of validity of acts of a State Legislature and the resolution of any doubts, if any, in favor of validity, the party challenging

the constitutionality of a State statute bears the heavy burden of proof showing invalidity which must be made clearly, fully and unequivocally. Mayo v. Lakeland Highlands Canning Co., 309 U.S. 310, 321-322 (1940); New York v. O'Neill, 359 U.S. 1 (1959).

Significantly, except for an oblique reference to Chapter 76 of the Laws of 1976 (e.g. Complaint, par. 101 JA 33), there is no direct allegation or proof that the 1976 standard of reimbursement of Public Health Law 2807(2)(e), as amended, is in direct conflict with the requirements and guidelines of the Medicaid Act requiring that a State plan must provide effective July 1, 1976, for "payment* * *on a reasonable cost related basis, as determined in accordance with methods and standards which shall be developed by the State on the basis of cost-finding methods approved and verified by the Secretary".

The phrase "reasonable cost related basis" is not defined in the Medicaid Act. 41 Federal Register [No. 128] [July 1, 1976] 27302. 45 CFR § 250.30 ("Reasonable charges")

describing the contents and requirements of a State plan for medical assistance states:

"(b) Upper limits. The upper limits for payments for care and services under a medical assistance plan are as follows: The State agency may pay less than the upper limits* * *"

An analysis of the legislative history of 42 U.S.C.A. 1396a(a)(13)(E) discloses that there was a "dissatisfaction with the flat rate payment system in general use, because it results in overpayment to some long-term facilities, while others are paid too little to support the quality of care that medicaid to need and receive, and because a flat rate system provides no incentive to upgrade the quality of care". 41 Federal Register at 27302. Public Health Law 2807(2)(e) - linking the quality of care rating (2803[1][c]) and the prudent-buyer concept (2808[1][a]) - establishes more precise guidelines for a system of reimbursement related to reasonable costs with built-in incentives to upgrade quality of care (see example relating to Mohawk Valley Nursing Home JA 1342). It was "designed* * *to provide adequately for plaintiffs' reasonable costs and encourage high quality residential health care facility services at the same time requiring cost efficiency pursuant to Public Health Law Section 2808"

(Dr. Steibel affid. par. 7 [JA 208]). The "60th percentile" for a "Good-State" rating (86-2.11[b] JA 534) is not equivalent to "60 percent of reasonable costs" which is outside the guidelines (41 Federal Register 27302 col. 3), as appellants mistakenly contend (Br. p. 36). The challenged regulations, 10 NYCRR Part 86-2 (JA 528-563), carry out the mandates and directives of Public Health Law, as amended (Chapter 76 of the Laws of 1976), and it is not otherwise alleged. Thus, Part 86-2 is derivatively entitled to a presumption of constitutionality, particularly since the plaintiff-appellants do not allege that Part 86-2 is not in compliance with its statutory source and authority.

Indeed, the District Court repeatedly observed that plaintiffs made "no attempt* * *to really explain why these new costs were not reasonable" (JA 1356) and on February 4, 1977, commented (JA 1854):

"THE COURT: I remember vividly finding nowhere any elaboration or explanation to show m[e] why the state had acted in a way that violated the requirements of reasonableness* * *there was a lot of complaint about the fact that costs were not being met, that rates were reduced* * *but, basically, they were talking about actual costs or actual losses and the translation of that into reasonableness, in my view, was simply not made* * *".

Their attempt now to make such an explanation on appeal, contending that "the rating system is unrelated to costs" (Br. p. 49) and assuming that the "percentiles" are somehow a "limitation" which "necessarily excludes reimbursement for expenses without any determination that they are unreasonable" (id. p. 50), is still based upon the same prior objection that they are not fully reimbursed for "actual costs" (Br. p. 51 line 17) overlooking the linkage mandated by 2807(2)(e) (§ 11[e] Ch. 76, L. 1976) of the quality of care rating (2803[1][c]) and the legislative standard that payment for costs "shall not exceed" the costs for supplies or services" which would be paid in the normal course of business by a prudent buyer* * *. The legislative reimbursement standard and concept of "prudent buyer" - a federal reasonable costs concept (20 CFR 405.45; Provider Reimbursement § 2103) - is obviously not a "defense", as appellants contend (Br. p. 51), and it was never so asserted. Part 86-2 expressly describes "the methods and standards used by the State for determining payments to be made on a cost-related basis* * *and for determining reasonable cost-related payment rates" (JA 525).

Extrinsic allegations and offers of evidence that "members of the plaintiff class will be unable to meet the costs of operating their facilities" (Complaint par. 82) (JA 29) and their threatened "involency" (id. par. 85) (JA 30) (see also Pl. Affids. JA 51 [par. 7]; 55 [par. 55]; 62 [par. 12] ["If* * *forced to close"]; 66 [par. 5] ["If* * *forced to close"] insofar as plaintiffs mean that their "actual costs" are not fully reimbursed under Public Health Law 2807(2)(e) and the regulations 10 NYCRR Part 86-2 (JA 527 et seq.), are irrelevant, insufficient and unconvincing to show a direct conflict with the federal standard "reasonable cost related basis" (42 USCA a[a][13][E]), as plaintiffs must do, to rebut the strong constitutional presumption of Public Health Law 2807(2)(e) and its regulations (10 NYCRR Part 86-2). The District Court observed (JA 1867):

"THE COURT: * * *it is the simplistic approach to tell me that there are homes which are suffering and I say to you that that does not make the case because, basically, what you are continually telling me is that they have actual costs in excess, and so forth".

Appellants' example (Br. p. 51) again demonstrates that their quarrel is a semantic debate with Part 86-2 - that they do not receive full reimbursement of actual costs -

reasonable or unreasonable. They mistakenly assume that the "60th percentile is used as the basis for excluding costs" from which they then attempt to infer that "some portion of the [actual] costs of 40 facilities admittedly with the "highest costs" would be "excluded from their reimbursement - regardless of whether their costs could be demonstrated in their entirety to be prudent, efficient or reasonable" (Br. p. 51). Admittedly, the 40 facilities out of 60 in the "Good-State" rating group have the "highest costs" - above the norm established by the costs for one of the six functions (e.g. "Food-Nutrition" 86-2.11[a][2]) by the 60th facility in the "per diem range of costs". Obviously, if the per diem range of costs for facilities receiving a "Good-State" quality rating is \$3.00 (zero percentile) to \$9.00 and the 60th facility has a food-nutrition cost of \$7.00, it must reasonably be assumed that the 40 facilities with the admittedly "highest costs" (Br. p.1 51) of \$8 to \$9, under the prudent buyer concept, should be able to do likewise. Accordingly, like the 60 facilities with a per diem range of cost of \$3 to \$7, they too will be reimbursed for costs up to \$7, but not for their extra \$1 to \$2 additional cost above \$7 which does not warrant an inference of efficiency

on economy under the prudent-buyer standard (2808[1][a]) which they exceed. Perhaps the 40 facilities in appellants' example may administratively apply under the review and revision procedures of Section 86-2.14 "Revision in certified rates" (JA 538) which includes inter alia "requests for waivers" (id. subd. [5]) and to establish to the Commissioner, for example, that their \$1 to \$2 higher costs are within the prudent-buyer concept. Appellants' comparison with the "former methodology of Part 86 which utilized 'averages'" and reimbursement "within 115% of the average" mistakenly assumes that "all" 100 of the facilities "would fall within 115% of the averages" (Br. p. 51). Nevertheless, there was no reimbursement for costs even under the former methodology exceeding the "115% of the average". This comparison does not support appellants' conclusion that a "ceiling limitation which automatically excludes portions of costs cannot possible produce reimbursement on a 'reasonable cost-related basis'" (Br. p. 51). By omitting the words "reasonable costs" in their assumption, appellants overlook the fact that the percentiles in each quality rating group - establishing norms within each group - do provide for reimbursement of costs above the lowest cost per unit in each range (e.g. \$3 for food-nutrition in the example supra pp. 19-21) and, indeed, reasonable costs established under the norm

for 60 facilities are reimbursed for all of the 100 facilities in the appellants' hypothetical.

Moreover appellants' hypothetical of a spread or distribution of costs "between \$53 per patient day and \$55 per patient day" which would exclude "actual costs" of 75 cents, is unrealistic to warrant a lawsuit by the de minimis higher cost of 75 cents especially when their hypothetical involves a composite of the six functions (86-2.11[a][2]) and overlooks Section 86-2.11[i](JA 536).

The range of percentiles (35th to 10th) (86-2.11 [c][d][e])(JA 534-535) from the "Good-State" rating for the lower quality ratings of "Good-Federal", "Needs Improvement" and "Unacceptable", is reasonable and reflects that each lower percentile meets reimbursement of reasonable costs at a lesser standard of quality which is presumably less costly. Nevertheless, a facility in the "Good-Federal" quality rating group will be reimbursed just like a facility at the 35th percentile of the "Good-State" quality rating - which still provides for reimbursement of costs above the lowest cost per unit in the "Good-State" group (e.g. \$3 for food-nutrition in the example supra pp. 19-21).

The percentile is not an arbitrary and unreasonable mathematical - percentage cut-off of actual costs as appellants try to make it appear; it is like a norm of the distribution of the "per diem range of costs for facilities receiving 'Good-State' service ratings for the appropriate size group" (86-2.11[b][e]) (JA 534-535) which would reasonably establish reasonable costs under the "reasonable cost related basis" reimbursement standard of 42 USCA 1396a(a)(E) which has been submitted on December 31, 1976, to the Department of Health, Education and Welfare (JA 521). The Department states that the percentile is not a 60th percentage; "[r]ather, we establish the lowest rate in each group at the reasonable cost base, and we permit facilities to exceed our lowest cost denominator on a ceiling basis" (JA 203).

Nor can appellants challenge the validity of Part 86-2 by comparison with the prior methodology under which facilities were "grouped" by "geographic location" (Br. pp. 46-48) under statutory authority repealed by Chapter 76 of the Laws of 1976. Moreover, they overlook Part 86-2(h) (JA 535) which provides:

"(h) In establishing the ranges of per diem costs, by function, facilities will be grouped without regard to sponsor or geographic

area. An economic leveling factor developed on the basis of area salaries will be used to make the costs comparable."
(emphasis added)

A management assessment evaluation of plaintiff Mohawk Valley by the professional staff of the Department of Health disclosed the existence of the inherent "incentive to upgrade the quality of care" - one of the criteria and congressional objectives (41 Federal Register 27302 col. 3). Dr. Cicero, the Deputy Commissioner, testified as to plaintiff Mohawk Valley which is rated in the "Needs Improvement" category, as follows (JA 1342):

"[DR. CICERO]: * * *it is our position that in addition to savings being made, simple redeployment of personnel among other things would change that rating from a needs improvement to at least a good federal* * * that would mean* * *a different ceiling and a higher ceiling would be applied with a simple redeployment of staff".

Appellants' offer of extrinsic proof of a rate "freeze" (Br. pp. 44-45; Complaint par. 47 [JA 16-17]) and their anticipation of an affirmative defense of the State's budgetary problems (Br. pp.40-43; Complaint par. 54 [JA 18-19] -

again using two more straw men to attempt to prove that Part 86-2 does not fully reimburse their actual costs - is a readily transparent attempt to tailor their challenge within the decisions of Catholic Medical Center of Brooklyn and Queens, Inc. v. Rockefeller, 305 F. Supp. 1256 and 1268 (E.D.N.Y. 1969), 430 F. 2d 1268 (2d Cir. 1970), app. dsmd. 400 U.S. 931 (1970); Massachusetts General Hospital v. Sargent, 397 F. Supp. 1056 (D. Mass. 1975) and other decisions (Br. pp. 39-40), which are not here relevant or controlling since there was no "freeze" of the 1975 rates (see, Kaye v. Whalen, ___ A D 2d ___ [3d Dept. 1977] [Apps. Supplement Part 9 at pages 4-5] reversing Special Term where petitioners alleged that the "Commissioner* * * simply froze the 1975 reimbursement rates" see opinion, id. Part 8 at page 4). An allegation of lack of State funds which appellants mistakenly anticipated as defendants' affirmative defense - improper pleading because such an allegation is not an integral part of plaintiffs' claim (5 Federal Practice and Procedure, Wright and Miller § 1276) - is an irrelevant circumstance which indeed has not even been asserted here by the defendant-appellees (see Answer JA 225-233). We are not defending a claim of a rate "freeze". Thus, appellants have not proven

a violation of the guideline in 41 Federal Register at 27303 (see Br. p. 36).

The Medicaid Act and its administrative interpretations do not impose upon the States a simple and rigid formula or methodology for reimbursement. On the contrary, the Department of Health, Education and Welfare in its interpretation commented (41 Federal Register [July 1, 1976] at p. 27303, col. 1):

"On the other hand, neither does the statute require that States provide assurance that each facility will be reimbursed its reasonable costs, as some comments urged. The intent expressed in the legislative history that States be allowed the maximum possible flexibility in developing cost-related payment methods sheds light on the distinction between 'reasonable cost' and 'reasonable cost-related'* * * A rigid requirement that a State pay to each facility the full amount of its allowable costs would bar the use of these very options that Congress meant to make available* * *".

(See also JA 1854-1867).

Besides, the alleged losses are not directly attributable to the alleged absence of "60 day notice" (Br. p. 2); Section 11 of Chapter 76 of the Laws of 1976, among

other things, established a time frame for Medicaid residential health care facility reimbursement and the statutory rate period began January 1, 1976 and ended March 31, 1977 (§ 2807[2][e] Section 11 took effect on March 30, 1976). Section 16 of Chapter 76 in effect repealed the former 60 day notice rule "from and after November 1, 1975". The new 60 day notice rule in Section 13 of Chapter 76 only applies to a future established rate period. Moreover, the rates for all the facilities in the purported class were not reduced on November 1, 1976, by Part 86-2; the records of the Division of Health Care Financing show that the rate issued November 1, 1976 for the period January 1-December 31, 1976 for 286 facilities "increased the reimbursement rate of 103 of the facilities, decreased the rates of 176 and remained the same for seven in comparison with the prior interim rates" (JA 221).

Moreover, some plaintiff facilities already had incurred unpaid debts to their suppliers (e.g. St. Cabrini JA 1328). Mohawk had a receiver appointed (JA 1341). The Record fairly demonstrates that notwithstanding prior knowledge of the enactment of Chapter 76 of the Laws of 1976 (See JA 1551 line 25 to 1552 "Selected meetings by regions"),

appellants did not immediately attempt to prepare and adopt cost-saving procedures. Instead, they resorted to an application for a quick temporary restraining order on short-notice to block the application of Part 86-2 and, in effect, to secure a roll-back to the 1975 rates upon a joint announcement in combination through their associations that they would close their doors - tantamount to the typical threat in a boycott when businessmen do not have their way. Appellants' reference to the recommendations for cost-savings for St. Cabrini (Br. p. 54) omits the Department of Health's offer of a "timetable" and for a "phase out schedule of [its] suggested cuts" (JA 1570).

Similarly, offers of extrinsic evidence of alleged "failure of defendants to comply with state and federal procedural requirements" (Br. Point II page 55 et seq.) - pendent state claims - are irrelevant, frivolous and make-weight. These tag - along procedural requirements: consultation with a medical care advisory committee (Br. p. 55); notice and hearing of proposed "reduction of benefits" (Br. pp. 58-62);* and State statutory procedural requirements for adoption of regulations (Br. pp. 62-64), even assuming their accuracy, are irrelevant to appellants' offer to prove invalidity of

* This claim was not alleged in the complaint.

Part 86-2 - their key issue and challenge that Part 86-2 does "not provide reimbursement on a reasonable cost related basis" (Br. p. 31).

Nothing in the Medicaid Act or in its regulations (45 CFR 246.10) mandates that a medical advisory committee approve an amendment to the State's plan by new regulations and rates implementing an act of the Legislature. Nor does Social Services Law § 365-c(2) so provide. Thus, no pendent state statutory violation can be alleged (Complaint Sixth Cause of Action JA 34).

Part 86-2 expressly provides for "methods and standards used by the State for determining payments to be made on a reasonable cost-related basis to skilled nursing and intermediate care facilities for services provided under the plan" (JA 525). Indeed, the Department of Health's recommendations for cost-savings emphasize that the "reductions" can be made "without causing irreparable harm to patient care" (Loretto Exh. "FF" JA 2132; JA 2105) and apart from "improve[ment]" of nursing care of patients", the savings would nevertheless "allow the facility to retain its 'Good-State' rating in nursing and provide nursing care more efficiently and effectively" (St. Cabrini JA 2111; Margaret

Tietz JA 2072). 45 CFR 205.10, upon which appellants rely (Br. p. 58), and their judicial precedents involving actual reductions in patients' benefits or care, are obviously here not relevant or controlling.

POINT II

THE DISTRICT COURT'S DENIAL OF
A PRELIMINARY INJUNCTION - PENDING TRIAL -
AN EXTRAORDINARY REMEDY CALLING FOR
ULTIMATE RELIEF AND A ROLL-BACK TO
THE REPEALED 1975 RATES -- SHOULD
BE AFFIRMED.

A preliminary injunction is an "extraordinary" (Weber v. Continental Motors, 305 F. Supp. 404, 406 [S.D.N.Y. 1969]) and a drastic remedy (Hershey Creamery Co. v. Hershey Chocolate Corp., 269 F. Supp. 45 [S.D.N.Y. 1967]) which the District Court in the case at bar correctly and properly denied, particularly, on a class-wide basis tantamount to calling for an across-the-board roll-back to the 1975 rates (see Complaint, par. 3 JA 44). The appellants' motion for a preliminary injunction, in effect, called for an order which would grant to the alleged class the ultimate relief demanded in the Complaint. But, the appellants have not here demonstrated the "combination or probable success on the merits and the possibility of irreparable injury, or in the

alternative, that [they] have raised serious questions going to the merits and that the balance of hardship tips decidedly in [their] favor" (Brown v. Williamson Tobacco Corp. v. Engman, 527 F. 2d 1115, 1121 [2d Cir. 1975]; see also Triebwasser & Katz v. American Telephone & Telegraph Company, 535 F. 2d 1356, 1360 [2d Cir. 1976])). Jimenez v. Barber, 252 F. 2d 550 (9th Cir. 1958) established that where an appellant applies for a temporary restraining order which would grant the ultimate relief, the appellant must show a great likelihood that he will prevail on the merits and he must show irreparable injury from a denial of the interim relief. Thus, a renewal of the motion for preliminary injunction pending appeal should be denied.

In the case at bar, the District Court correctly and properly exercised its discretion denying a preliminary injunction to an alleged class; no real irreparable injury to the class was demonstrated by the appellant associations or by appellant owner-operators of nursing home facilities. Indeed, it is doubtful that the plaintiffs are truly representative of any class as evidenced by the fact, as the District Court found, of "a wide and substantial discrepancy as to the issues as to each individual home" (JA 2020).

The District Court in its "findings and conclusions", held (JA 2020-2021):

"THE COURT: * * *The record amply demonstrates that there are differences in the rates granted to the homes.* * * There are differences with respect to the procedures engaged in by the Department of Health and the Department of the Budget with respect to these homes. There are differences, substantial differences, in the financial condition of the different homes. There are substantial differences in the effect of the various rates* * *".

The District Court did reserve "decision with respect to individual cases of individual homes that wish to present evidence to me* * *" (JA 2023) and observed "I have never been requested to have a further hearing" (JA 2148).

Moreover, there is ample protection against any cessation of operations not only by the prior administrative approval required by the State Hospital Code (10 NYCRR §§ 401.3[f], 801.3[f]) and the State's plan in which the nursing home facilities are an integral part (see Dr. Haughie affd. JA 199-201), but by "administrative proceedings and inquiries" (JA 2148) - in effect a phase-in procedure for the new 1976 rates. Accordingly, the District Court's denial of a preliminary injunction should be affirmed.

POINT III

THERE IS NO DEMONSTRATION BY
APPELLANTS OF A LIKELIHOOD OF
SUCCESS ON THE MERITS WARRANTING
A PRELIMINARY INJUNCTION GRANTING
AN ULTIMATE MANDATORY ROLL-BACK
OF RATES

The "normal function of the preliminary injunction is to maintain the status quo pending a full hearing on the merits [citations]" (Triebwasser & Katz v. American Telephone & Telegraph Company, supra, 535 F. 2d at 1360 [2d Cir. 1976]). But appellants do not here merely seek to maintain the status quo; their proposed preliminary injunction enjoining the application of the Part 86-2 [1976] rates effective November 1, 1976, in effect, called for affirmative relief calling for a roll-back to the 1975 rates as demanded in the Complaint (JA 44, par. 3) notwithstanding the repeal of their statutory and legislative authority and legislative appropriations by Chapter 76 of the Laws of 1976 amending the New York Public Health Law.

Plaintiff-appellants' bare allegations that Part 86-2 regulations "violate" (Complaint pars. 87, 97, 101) (JA 30, 33) the Medicaid Act (42 U.S.C. 1396[a][13][E], are

legally insufficient to invoke the application of the Supremacy Clause in Article VI clause 2 of the United States Constitution. No direct conflict is shown. See, Kelly v. Washington, 302 U.S. 1, 10 [1973]) reemphasized in DeCanas v. Bica, 424 U.S. 351 (1976). New York's "methods and standards" developed pursuant to the Congressional mandate of 1396a (a)(13)(E) "which shall be developed by the State" are not in direct conflict with the Medicaid Act's standard "reasonable cost related basis". Indeed, the Associate Regional Commissioner of the U.S. Department of Health, Education and Welfare in a letter dated September 30, 1976 responded to the Deputy Commissioner of Social Services, as follows (JA 212-213):

"As you can see, our regulations have not previously required DHEW approval of the reimbursement methodology developed by the States for SNFs and ICFs. Therefore, revisions to rates for periods prior to the implementation of 250.30(a)(3), (December 31, 1976) are not contrary to Federal regulations insofar as they meet the test of not exceeding amounts paid under Title XVIII".

Plaintiff-appellants' claim for an injunction to the challenged retroactive application of Part 86-2 is barred by the Eleventh Amendment to the U.S. Constitution. Edelman v. Jordan, 415 U.S. 651 (1974).

The plaintiff-appellants' pendent state claims calling for judicial review of state administrative requirements (e.g. Sixth-Tenth Causes of Action) relying upon the Special Term decision of Kaye v. Whalen (Complaint, par. 108) (JA 35) do not present federal constitutional claims. Besides, the Supreme Court, Appellate Division, reversed (3-2 decision) the decision of Special Term on February 14, 1977 and dismissed the Article 78 petition in Kaye v. Whalen,
_____ A D 2d _____ (3d Dept. 1977).

CONCLUSION

THE DISTRICT COURT'S DENIAL OF
APPELLANTS' MOTION FOR A PRELIMINARY
INJUNCTION APPLICABLE TO THE CLASS
SHOULD BE AFFIRMED IN ALL RESPECTS
WITH COSTS

Dated: New York, New York
April 4, 1977

Respectfully submitted,

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